STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. L-10/13-731
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals decisions of the Economic Services Division of the Vermont Department for Children and Families (DCF) terminating his eligibility for Medicaid under the Working People with Disabilities (WPWD) program, finding him ineligible for the Medicaid Buy-In program, and establishing a spenddown for future Medicaid eligibility.

FINDINGS OF FACT

1. The petitioner is a sixty-seven-year-old man who has been receiving Medicaid as a disabled person under the Working Persons with Disabilities (WPWD) program for a number of years. He is self-employed as a peer counselor at various non-profit institutions. He has also received Medicare since February, 2004. He lives in a one person household outside of Chittenden County.

2. In June of 2013, during a review of his Medicaid eligibility, the petitioner was asked to verify that he was still employed by providing his 2012 federal tax forms. The

petitioner had not filed a tax return and was unable to provide that information.

3. On June 26, 2013, the petitioner was notified that his Medicaid would end because he was no longer working and was thus ineligible for the WPWD program. His countable income of $1,406.06[1] was determined to be too high to qualify for SSI-related Medicaid and he was told that he could only qualify for Medicaid if he incurred medical expenses of $1,854 over the next six months.

4. The petitioner disagreed with this action because he was still working and was given an income and expense form to fill out. The form reported that he had about $1,300 per year in income and $108 in expenses. DCF determined that the petitioner had $99.33 per month in countable income. The petitioner does not dispute that finding. Over the next few weeks the petitioner was also asked to submit a business plan which he did and then an update to that business plan which he also provided.

5. On August 27, 2013, the petitioner was notified that he was ineligible for WPWD because, "it only cover (sic) you

[1]That figure was determined by adding countable earned income of $1,388.90 (total unearned income of $1,408.90 minus a standard $20 disregard) to the petitioner's countable earned income of $17.16 (total earned income of $99.33 minus a standard $65 disregard minus 50 percent of the remainder), for a total of $1,406.06.

until you turned 67 in June." DCF had actually discovered in the course of reviewing the petitioner's applications and plans that the petitioner was no longer receiving SSDI benefits but rather social security retirement benefits. The action was taken because DCF only disregards SSDI, not social security retirement benefits, in calculating eligibility for WPWD. The notice, however, fell far short of conveying that information to the petitioner.[2]

6. The petitioner complained to the health care ombudsman that he had been denied WPWD benefits because of his age. The ombudsman contacted DCF who agreed to have another look at his case. On September 27, 2013, the petitioner was notified that he had been found eligible for the WPWD program again.

7. However, that determination was reversed on October 1, 2013. The petitioner was told that his Medicaid would end on October 11, 2013 because "While previously we were able to exclude your SSDI income, that income is now SSA income and we are unable to exclude it from your monthly income. Based on your current SSA income and employment income your current monthly income is over the Federal poverty level and

[2]The petitioner was also notified that he was determined ineligible for CHAP and VHAP benefits due to his receipt of Medicare. He is not disputing those determinations.

therefore you are not eligible for Working People with Disabilities. Please feel free to call in if you have any questions regarding this."

8. That same notice established a spenddown period for the petitioner beginning November 1, 2013 and ending April 30, 2014. The spenddown amount of $1,854 for this period was determined by including his social security income of $1,408.90, disregarding $20 of that income, disregarding his $99.33 monthly earnings and comparing the balance, $1,388.90 to the 2013 Medicaid protected income amount of $975. The difference between those two figures, $413.90 was determined to be the monthly spenddown amount which was then multiplied by six to get the semi-annual amount of $2,483.40. DCF then deducted the amount of the petitioner's Medicaid premium for the next six months, $629.40, and arrived at a final spenddown of $1,854.

9. The petitioner timely appealed that decision and his Medicaid benefits were continued. At hearing and in subsequent correspondence, the petitioner complained about the confusing and contradictory notices, saying that it was placing undue stress on him. In addition to challenging the Department's refusal to disregard his social security retirement income from calculations for WPWD, he asked DCF to

consider whether or not he might be eligible for Medicaid "buy-in" programs and whether or not new Medicaid eligibility limits of 138 percent, which were due to begin on January 31, 2014, might make him eligible for a smaller spenddown.

10. DCF responded by saying that he was not financially eligible for three of the Medicaid "buy-in" programs, QMB, SLMB, and QI-1 because of excess income and for a fourth one, QDWI because it was only available to disabled persons who lost Medicare because they returned to work. DCF also said that the new health programs effective January 1, 2014, still used the standard PIL for SSI-related Medicaid, and not 138 percent of the poverty level.

ORDER

All of the decisions of DCF, including its decision that the petitioner is not eligible for WPWD, is not eligible for the Medicaid buy-in programs, and that he has a six month spenddown of $1,854 for Medicaid eligibility is affirmed.

REASONS

At all times relevant to this appeal, both before and after January 1, 2014, the petitioner has been categorically eligible for Medicaid as either a disabled or elderly person. See MM § 4202.1 and Health Benefits Eligibility and

Enrollment, Amendment #2, Bulletin 13-46E (1/1/14)) (hereafter HBEE), § 8.03. The financial eligibility maximum, or the protected income level (PIL,) for the SSI-related program for a household of one in 2013 was $975 per month and increased on January 1, 2014 to $991 per month.[3] (Procedures Manual 2420B(1) (1/1/14).

Although the petitioner has had income which is over $400 in excess of the Medicaid PIL, he has been found financially eligible for several years under a special program for working persons with disabilities (WPWD). The regulations governing this program provide, in pertinent part:

The following individuals are eligible for SSI-related Medicaid as categorically needy. . .

> B. Working people with disabilities - Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid and whose:
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> . . .
>
> 2. income is below 250 percent of the federal poverty level (FPL) associated with the applicable family size;
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> 3. income does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level[4] for two, whichever is higher, after disregarding the

[3] The PIL is roughly $75 more per month for residents of Chittenden County.

[4]The SSI maximum payment for a two person household with one disabled person is $710 per month.

> earnings, social security disability insurance benefits (SSDI), and any veterans disability benefits of the individual working with disabilities . . .
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> MM 4202.4B[5]

Under paragraph (3) of the above regulation, DCF had been disregarding all of the petitioner's income because it consisted of only excludable social security disability insurance (SSDI) benefits and earnings. Following the month when the petitioner turned 66[6] in June of 2012, he no longer received SSDI benefits but rather social security benefits based on the fact that he had now reached his full retirement age. Under the above rule in paragraph (3), DCF should have stopped disregarding the petitioner's social security benefits in July of 2012 because they are not listed as excludable. DCF, however, did not notice the change in the type of benefits received (likely because the amounts were the same) and the petitioner continued to receive Medicaid until his benefits were recalculated using the social security income in August of 2013.

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[5]The Vermont Health Connect program has retained the same eligibility criteria for the WPWD program beginning January 1, 2014. See VHC Bulletin 13-46, Rule 8.05(d).

[6]Notes on the petitioner's notices indicated that DCF thought the change occurred at age 67 but that is erroneous. However, since no one disputes that the petitioner had been receiving social security retirement benefits at least by the time of his denial, the error is harmless.

The above regulations lay out a sequential evaluation. First, anyone who has over 250 percent of the monthly FPL (in 2013 $2,394 for a one person household, in 2014, $2,432, P2420B1) from a combination of countable earned and unearned income is ineligible at that step. The petitioner did not have that much income in total so he was not eliminated by the 250 percent rule and moved on to the second step. The second step considers whether the applicant has countable income in excess of the PIL. In the past, the petitioner passed that step as well since under the above regulation all of his social security disability income was disregarded. However, when that income became social security retirement income the regulation no longer allowed it to be disregarded. Without that disregard, the petitioner's countable unearned income of $1,406.06 was much greater than the maximum allowed under the Medicaid PIL for a one person household which in 2013 was $975 and in 2014 is $991. (P2420B(1)). This being the case, the petitioner is ineligible for the WPWD program in either 2013 or 2014. Under this regulation, which grants generous maximums for the working disabled, the petitioner could have earned countable income of $2,394 and still have been Medicaid eligible. But he could only have gotten this benefit if his countable unearned income--the social security

retirement benefit--had been under the PIL. DCF was correct in finding that he is not eligible for WPWD.

Although DCF correctly applied the regulation, the petitioner argues that the regulation is unfair because it takes away his Medicaid when his situation has not changed. He argues that it is even more important to encourage older persons to work and to support them in their efforts to sustain themselves. As a policy matter, the petitioner may have a valid point but even if the Board were to agree, "the Board has no authority to substitute its own policy views for that of the Department." Fair Hearing No. 16,258. DCF and the federal government have set the eligibility parameters for Medicaid and they are clear. Absent a showing that these regulations conflict with state or federal law or are unconstitutional, the Board has an obligation to uphold them on appeal. 3 VSA § 3091(d), Fair Hearing Rule 1000.4D.

Even though the petitioner is no longer eligible for Medicaid under the WPWD program, he is still categorically related to SSI due both to his disability and his age (see MM 4202.5(2)(d)) and as such becomes eligible as a medically needy person. The regulations on medically needy individuals provide, in pertinent part:

> Individuals who would be members of a categorically needy coverage group may qualify for Medicaid as medically needy even if their income or resources exceed coverage group limits. These individuals may become eligible if they incur enough non-covered medical expenses to reduce their income to the applicable standard. For community Medicaid, individuals must reduce their income to the protected income level (PIL). . . .
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> MM 4203[7]

In short, after losing his WPWD eligibility, the petitioner's financial eligibility reverts to the normal method of calculating such eligibility which requires the counting of all income (minus some disregards) and the comparison of that income to the PIL for a household of one. As stated, previously, the petitioner's income is in excess of the PIL and so he can no longer be found automatically financially eligible for Medicaid. However, under the above regulation, he can establish financial eligibility by showing that he is "medically needy", that is, that he has enough non-covered medical expenses to reduce his income to the PIL level.

DCF regulations require that the spenddown be calculated, in pertinent part, as follows:

> The amount of a Medicaid group's spenddown is the amount by which their countable income or resources

[7] This provision is also retained in the new Vermont Health Program. HBEE, § 8.06.

> exceed the applicable standard for the accounting period. An individual with income greater than the protected income level (PIL) may spend the excess down to the PIL on medical expenses following the methodology specified below to receive community Medicaid as part of the medically needy coverage group . . . and a six-month accounting period applies to those in the community living arrangement.
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> MM 4440[8]

The Department followed this methodology when it notified the petitioner that his spenddown would be the difference between his countable income and the PIL. The petitioner's countable income was correctly calculated by adding his countable unearned income (social security retirement minus a $20 disregard) to his countable earned income (earnings minus $65, minus 50 percent of the remainder). MM 4281.1. That figure, $1,388.90[9], was correctly compared to the PIL for a household of one of $975. The difference, $413.90, became the monthly spenddown amount. MM 4281.

That figure was then multiplied by a six month accounting period as required by the regulations, for a total of $2,483.40. MM 4421. Finally, the petitioner was given a

[8] This methodology is also retained in the new Vermont Health Connect program. HBEE, § 30.

[9] In calculating his countable income for the spenddown, DCF did not include the $17.76 balance from his earned income, a decision which works in the petitioner's favor. Perhaps DCF considered the income too sporadic to count.

credit up front for his predictable Medicaid premium expenses for the entire six month period, $629.40. MM 4443.1. DCF correctly calculated the petitioner's spenddown as being $1854 for the six month period under Medicaid regulations in effect in 2013.

However, the petitioner argues that DCF should compare his countable income to the new maximum eligibility criterion of 138 percent ($1,343, P-2520B(1)) found in the 2014 Vermont Health Connect Medicaid program, not to the PIL. While this argument seems to come from a popular belief that the new eligibility level for Medicaid has been raised for all, the regulations do not support the petitioner's belief. To begin with, the 138 percent of Federal Poverty Level is only adopted in the Medicaid for Children and Adults (MCA) section of the Vermont Health Connect program. See HBEE, § 7.03(a)(5). The petitioner is not eligible for the MCA program because he is over age 65. HBEE, § 7.03(a)(5). In addition, the spenddown program for MCA only includes individuals under age 19, pregnant women, and parent and caretaker relatives of children. HBEE, § 7.03(a)(8)(i). Those individuals' eligibility under the spenddown program is determined by comparing their countable income to the same PIL used in the petitioner's case. HBEE, § 7.03(a)(8)(ii) and (iii). Other

adults between the ages of 19 and 65 in the MCA program (widely known as "expanded Medicaid") are excluded from the spenddown program unless they have another categorical relation to Medicaid. If adults without another categorical connection to Medicaid are over these limits they have the option of applying for the health care exchange.

There is no PIL at 138 percent of income available to anyone in the Medicaid program for spenddown purposes. DCF correctly used the 2013 PIL to calculate the petitioner's spenddown. As that PIL has increased since the appeal was filed, the petitioner may ask DCF to recalculate his future spenddown amounts using the 2014 PIL which should make a difference of around $100 in the total amount of expenses the petitioner needs to incur to re-activate his Medicaid.

With regard to the Medicaid premium buy-in program, the petitioner is eligible to participate in those programs only if his countable income is less than or equal to the maximum guidelines which are expressed as a percentage of the federal poverty level. The Qualified Medicare Beneficiary Program (QMB) has a maximum of 100 percent of FPL which for 2013 was $958 for a one person household and in 2014, $973. MM 4204.1, P-2420B(2). The Specified Low Income Medicare Beneficiary Program (SLMB) has a maximum of

120 percent of FLP which in 2013 was $1,149 for a one person household and in 2014 is $1,167. MM 4204.3, P2420B(2). The Qualified Individual-1 program (QI-1) has a maximum of 135 percent of FLP which for 2013 was $1,293 for a family of one, and in 2014, is $1,313. MM 4204.4., P-2420B(2)[10] The only other program, Qualified and Disabled and Working Individuals (QDWI) which has a 200 percent of FPL maximum is only for persons who were disabled and lost Medicare due to returning to work. MM 4202.2. That latter category does not include the petitioner. While the petitioner, with countable income of $1,388.80, is only about $75 over the limit for the 2014 QI-1 program, there is no spenddown associated with this program. DCF's decision finding the petitioner ineligible for assistance with his Medicaid premiums is correct.

Although the petitioner's income is only at about 150 percent of the poverty level, his receipt of retirement and Medicare benefits puts him at a disadvantage for benefiting from DCF's health care programs. He has too much income to get assistance with paying his Medicare premiums and too much social security retirement income to get Medicaid

[10] All of these programs are retained in the Vermont Health Connect program with the same eligibility levels. They are found at HBEE, § 8.07.

through the working disabled program. Furthermore, he cannot participate in the health exchange programs because, under the regulations, the Medicare he is receiving is considered to meet "minimum essential coverage." HBEE § 23(b)(1)(i). Although the spenddown program does give him credit for payment of his Medicare premium, it still requires him to pay a considerable amount out of his own pocket before Medicaid begins to cover him again. This is no doubt difficult for someone in the petitioner's position but the rules do not allow for any other outcome.

The petitioner has expressed his frustration over the contradictory notices he received over the three month period last summer and the uncertainty during the appeal period which has placed him under a lot of stress. It is true that the initial notices did not provide him with accurate information about the reasons for his termination, first saying it was because he was not working, then that it was because of his age, and then erroneously telling him that he was eligible after he complained to the ombudsman.

But the Department finally did give the petitioner a correct notice with a full explanation of why the action was taken on October 1, 2013 which he appealed. During all of this time continuing up to the present, the petitioner's

Medicaid benefits continued uninterrupted while his eligibility for Medicaid benefits under the old and new programs and changed income levels was thoroughly explored. The petitioner has been receiving Medicaid benefits for which he was not actually eligible since June of 2012. DCF will make no attempt to recoup those benefits because it made the error, not the petitioner. As DCF's decisions were in accord with its regulations, the Board is bound to uphold them. V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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